East Kent Hospitals University NHS
NHS Foundation Trust

MY WARD –MY TEAM

DOCTORS 4 DOCTORS

INDUCTION INFORMATION

UROLOGY
CLARKE WARD

KENT & CANTERBURY HOSPITAL

The list

The day/evening before someone add the TCIs (to come ins) to the bottom of the list.

- Go onto patient centre
- Left hand side under 'patient lists' select 'TCI list' and chose 'Clarke Ward' as the location and select the next day's date
- A list will come up of all the TCIs (to come in). These are all the patients who are coming in electively for surgery the following day.
- Add them to the TCI table at the bottom of the list for the next day
    - Add as much information as possible as it saves time in the morning i.e. consultant, date of arrival, name, hosp ID, DOB, type of surgery
    - Put all of it in *italics*
    - On the day you can find the bed numbers for the TCIs on the white board by the main patient board

Hot patients are any patient initially admitted as an emergency (i.e. not electively). These patients remain **hot** for the duration of their stay, even if then end up as medically fit for discharge and are awaiting social care. These patients are **bold** on the list.

Cold patients are any patients initially admitted electively. On day 1 of their admission they are in *italics* and are called a TCI. They do not need to be seen (though there may be jobs to do - see TCI section below). From day 1 post-op they are in normal writing (not bold or italics) and are seen on the **cold** ward round. These patients remain cold even if they become very sick post-operatively and have a prolonged stay in hospital.

TCIs come in throughout the day and don't need to be seen *pre-operatively*. There may be jobs that the nurses will write on the jobs list and ask you about - such as prescribing regular pain medications, taking blood if requested by surgeons/anaesthetist, doing other investigations as required e.g. ECGs pre-operatively, but nothing routine. *Post-operatively* try to look at their post-op notes as soon as possible once they are back on the ward. There will be a post-op plan. Sometimes this is just 'monitor overnight, discharge tomorrow on 5 days of trimethoprim' for example. Sometimes there are immediate post-op plans such as 'U&Es post-op please, or refer to MDM and discharge today'. Many are day cases and will need an EDN doing and to be sent home. If you're lucky the EDN may have been done in theatres (officially it should have been but this is rare).

Outliers are generally on Kent or ITU/HDU. You won't always be aware of them so when you're doing the list it’s a good idea to look at these two wards.

Jobs list

On the computer there is also a jobs list (an empty table with all the bed numbers).

Stick this to the desk and update it after ward round with all the jobs.

Some tips

- Be thorough with recording all the jobs - check the notes again if you didn’t catch everything during ward round

- Have boxes to indicate if things have been done
- Have a system for allocating jobs - we write our initials in the box of the job we've taken, you could allocate patients or bays, it's up to you.
- Nurses will add jobs to this list so keep checking it
- Write 'post op' next to all the TCIs to keep track of who's post-op notes have been checked when they are back on the ward
- Good idea to run through the list at about 3pm to check you're on top of things

Ward round

Ward round starts on the dot of **08:00** and the list needs to be ready and printed for that time

- Surgeons need to go to clinic/theatre for 08:30 so a late list means a late ward round which results in less time spent with each patient

Organise this as you think best but currently we operate the following system:

- One junior (usually F1 though F2s are welcome to volunteer too!) arrives at **07:30** each day to update the list
- Alternate who comes in early
- The other juniors arrive at about **07:50** and write all the observations in all the notes *except* the TCIs as they will not be seen pre-op.

Discharge information

On the desktop computer at the main desk there is a document called *Clarke Ward Discharge Bible*. This has information specific to different procedures e.g. all nephrostomies need 28 days clexane, circumcisions must abstain from sex for 4 weeks. Very useful document. Please feel free to update it as much as you'd like!

Check post-op notes and ward round plans for anything that needs doing for the patient post-discharge. Make sure these jobs are all done and note this in the notes and on the discharge summary.

- *Patient to be booked for TWOC/flexi-cystoscopy/any surgical procedure* requires a **TCI form** to be filled in. These are paper forms found at the end of the notes' trollies.
    - Attach a patient sticker
    - Fill in the form as per the example one pinned on the wall above the hand-in tray
    - Consultant name, date form filled in, diagnosis (sometimes a diagnosis, sometimes a procedure e.g. haematuria or urinary retention or TURBT etc), procedure required (flexible cystoscopy or TWOC or stent removal etc). If you know where you want it done then tick the box. **Sign it** at the bottom of the page.
    - Place in the hand-in tray on the side by the main desk near the blood form clip board
- *OPA in 6 weeks with AXR prior to appointment* is often written when patients have had lasers to stones
    - Book outpatient appointment via the EDN system for 6 weeks' time

    - Order and abdominal x-ray via patient centre --> write in the booking form 'patient to have AXR in 6 weeks prior to Urology OPA'
    - Inform the patient to go to the x-ray department a few hours before their outpatient appointment. They will have the x-ray and then they should go to the Urology outpatient clinic in time for their appointment.
- *Patient to be discussed at stone meeting* requires a stone meeting referral form
    - With the TCI forms at the end of each of the trollies
    - Fill in form and place in hand-inn tray
    - Stone meetings are at 12:45 on a Wednesday - **NB.** you can attend these, there is usually a free lunch
- *Patient to be discussed at MDM* requires an MDM referral form
    - At the end of each of the trollies with the other forms
    - Fill in form and place in hand-in tray
    - Results of MDMs can be found on patient centre in patient documents, or on EPR

Histology

- Any patient with a sample sent for histology (usually from TURBT, TURP, nephrectomy or biopsies)
- Histology takes about 2 weeks to come back
- OPA in 3-4 weeks to discuss histology (write this in EDN)
- Some, but not all, will need MDM referral (this will be requested in the surgical post-op plan)

Nephrectomies

- Group and save pre-op
- Post-op expect some rise in inflammatory markers and creatinine --> monitor for fevers and monitor urine output (N.B. urine output also sometimes a little low and picks up the next day but beware AKI in their only remaining kidney!)
- 28 days clexane
- Generally removed due to cancer so histology will be sent
    - MDM form
    - OPA with named consultant in 3-4 weeks to discuss histology

RALP (robot-assisted laparoscopic prostatectomy)

- Group and save pre-op
- Set proforma for every prostatectomy patient
    - Drain removed next day
    - Mobilise asap
    - Home next day
    - TWOC 7-10 days (usually appointment is pre-booked and therefore no TCI form needed, check with patient or urology suite)
    - PSA in 5 weeks (1 week before clinic) - print a blood form and give it to the patient
    - OPA in 6 weeks with named consultant
- EDN also has a proforma
    - Click on the 'extra data' tab at the top of the EDN page

    - Under 'templates' select 'prostatectomy' - this will then provide you with a set proforma for clinical details and management
    - Add anything extra in the notes section
- Medications also has a proforma
    - In the medication selection of the EDN under the box for 'comments for the GP' is a drop down menu - select 'prostatectomy' (though note this isn't up to date)
    - Standard drugs are paracetamol 1g QDS 28 days, ibuprofen 400mg TDS 28 days, solifenacin 50mg OD 28 days, lansoprazole 30mg OD 28 days, movicol 1 sachet BD 28 days

Circumcision

TURBT

- Transurethral resection of bladder tumour
- Common pathway is as follows:
    - Haematuria
    - Referred under 2 week wait for flexible cystoscopy
    - Bladder tumour found
    - Referred for a TURBT
- This often happens electively
- Sometimes it is an emergency: Someone presents with heavy haematuria and requires a 3-way with irrigation and bladder washouts. During investigation in hospital a tumour is found. Either the bleeding stops and then they come back for an elective TURBT, or the bleeding stops and we still do it as an inpatient, or sometimes a TURBT has to be done in order to stop the bleeding.
- Sometime sit is done palliatively in order to stop bleeding
- Follow-up/EDN
    - Medications: home with analgesia if needed
    - Histology has usually been sent (check surgical pathway to confirm as sometimes only diathermy is performed) and this takes 2 weeks to be processed
    - Follow-up OPA 3-4 weeks
    - MDM referral if requested

TURP/TURIS

- TURP = transurethral resection of prostate
- TURIS = transurethral resection (of prostate) in saline
- TURPs used to be done in glycine, now the majority of them are done in saline making it a TURIS (transurethral resection in saline). Even if it says TURP it is usually

ISD and ISC

- If anyone is doing either of these then refer to Urology Suite so that they can be taught to do it properly, provided with the equipment and provided with appropriate follow-up
- ISD = intermittent self-dilatation
    - Performed once weekly to prevent urethral strictures
- ISC = intermittent self-catheterisation

- Performed to empty bladder
- The more regularly it is performed the better but you need to balance this with the patient and their motivation

Consultants

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